

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-8

## CERTIFICATE OF DEATH

06020, 83  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Harford  
City or town Taylor  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 weeks  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Harford  
City or town White Hall, P.D.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Henrietta Adams

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow  
6. (b) Name of husband or wife John H. Adams  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Sept 23 1872  
8. AGE: Years 73 Months 9 Days 7 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rocks Harford co md  
(Town, county, and state)  
10. Usual occupation House wife

### 11. Industry or business

FATHER 12. Name Samuel Harman  
13. Birthplace Penna  
MOTHER 14. Maiden name Elizabeth Smeltzer  
15. Birthplace Penna

16. Informant J. Roy Adams  
Address White Hall md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof July 3 46  
(month) (day) (year)  
Cemetery or crematory St Paul  
Location Dyllesville

18. Funeral director Martin Skutzb  
Address Jarrettsville md

19. July 3rd 46 Thomas R. Brown  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 46 at 2:00 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 43 to June 30 46  
and that I last saw him er alive on June 30 46

Immediate cause of death Carlinoma of uterus  
DURATION  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE G. M. France  
M. D. or other \_\_\_\_\_  
Address Parkton, md Date signed 7/1/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

06021

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County Harford  
 City or town Garrettsville (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 46 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Harford  
 City or town Garrettsville (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Martha Ellen Bevard

## 3. (b) Social Security Number

4. Sex F. 5. Color or race white 6.(a) Single, married, widowed, or divorced widow  
 6.(b) Name of husband or wife George T. Bevard  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Jan. 19, 1869  
 8. AGE: Years 77 Months 5 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Garrettsville, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Elijah Rockhold

13. Birthplace Harford Co. Md.

14. Maiden name Margaret Ayres

15. Birthplace Harford Co. Md.

16. Informant Samuel S. Bevard

Address Rocke, R.D. Md.

17. Burial Date thereof June 22, 1946  
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Bethel

Location Madonna, Md.

18. Funeral director Martin G. Kurtz

Address Garrettsville, Md.

19. June 22 1946 Thomas R. Brown  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1946, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to June 19 1946  
 and that I last saw erg alive on June 19 1946

Immediate cause of death Terminal pneumonia DURATION 3 days

Due to Cerebral vascular accident with paralysis 6 mo.

Due to Hypertensive cardio-vascular disease 2 years

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles A. Neff MD

Address Street, Md. Date signed 6-20-46

RECEIVED  
JUN 26 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE CORPORATE LIMITED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 06022

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County HarfordCity or town Harrietts Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 29 yrs

Hospital, institution, or street address where death occurred:

659 Green St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County HarfordCity or town Harrietts Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 659 Green St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Nellie Starr Bonney

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Charles P. Bonney

## 7. Birth date of deceased (mo., day, yr.)

Aug. 20, 1872

6. (c) If alive, give age years

## 8. AGE:

Years 73 Months 10 Days 4 If less than one day  
..... hrs. .... min.

## 9. Birthplace

Wilmington, Del.  
(Town, county, and state)

## 10. Usual occupation

House Duties

## 11. Industry or business

Widow Bracken Starr

## 12. Name

Del.

## 13. Birthplace

Mary E. Knott

## 14. Maiden name

Del.

## 15. Birthplace

Mr. Charles P. Bonney

## 16. Informant

659 Green St. City

## 17. Burial

Funeral Home Date thereof Jan. 27, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

## 18. Cemetery or crematory

Harrietts Grace M.D.

## 19. Location

R. Madison Mitchell

## 20. Funeral director

Harrietts Grace M.D.

## 21. Address

June 26 1946

## 22. (Date rec'd by registrar)

G. L. Lewis M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

## Immediate cause of death

Arteriosclerotic C.V. Disease

## DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Dr. C. Palmer M.D.23. SIGNATURE Deputy Medical ExaminerHarford County M.D. or otherAddress Baltimore Md. Date signed 6/23/46

RECEIVED  
JUN 28 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

06023

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Hartford  
 City or town Bell Air Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 years  
 Hospital, institution, or street address where death occurred:  
Hartford Co., Home  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Hartford  
 City or town Bell Air, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Frank Caponic

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct 1 - 1874  
 8. AGE: Years 71 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Hartford Co., Md  
 (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

FATHER  
 12. Name Franklin Caponic  
 13. Birthplace Germany  
 MOTHER  
 14. Maiden name Mauda Sprader  
 15. Birthplace Germany

16. Informant Hartford Co. (Records)  
 Address Bell Air, Md

17. Buried Date thereof June 5/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hartford Co. Home -  
 Location Bell Air, Md. Rural  
Quain & Foster

18. Funeral director Belam 'ma  
 Address 4/15 40 Pissilla Lowwood

19. 6/15 19 46 Pissilla Lowwood  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 46 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

not treated previously and that I last saw him alive on June 4 19 46

Immediate cause of death Coronary Thrombosis  
 DURATION 1 hr

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Willard P. Hudson M. D. or other \_\_\_\_\_

Address Forest Hill, Md Date signed 6/5/46

RECEIVED

JUN 10 1946

BUREAU V F



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06024

Reg. Dist. No. 181

1. PLACE OF DEATH: *Harford*  
 County.....  
 City or town.....*Aberdeen*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*6 mos*  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*Md.* County.....*Harford*  
 City or town.....*Aberdeen*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

3. (a) FULL NAME  
*John Franklyn Carlile*

3. (b) Social Security Number

4. Sex.....*Male* 5. Color or race.....*White* 6. (a) Single, married, widowed, or divorced.....*Married*  
 6. (b) Name of husband or wife.....*Annie E. Carlile*  
 6. (c) If alive, give age.....*66* years  
 7. Birth date of deceased (mo., day, yr.).....*Apr. 10, 1870*  
 8. AGE: Years.....*76* Months.....*1* Days.....*25* If less than one day.....*hrs.*.....*min.*

9. Birthplace.....*Harford Co. Md.*  
 (Town, county, and state)

10. Usual occupation.....*Retired*  
 11. Industry or business.....*abu. P.W. Ground.*

12. Name.....*John Carlile*  
 13. Birthplace.....*Penn.*

14. Maiden name.....*Sarah Patterson*  
 15. Birthplace.....*Penn.*

16. Informant.....*Mrs. Annie E. Carlile*  
 Address.....*Aberdeen Md.*

17. *Burial* Date thereof.....*June 9, 1946*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*Mt. Zion*  
 Location.....*Harford Co. Md.*

18. Funeral director.....*R. Madison Mitchell*  
 Address.....*Navajo Grace, Md.*

19. *June 8* 19*46* *Nellie E. Cole*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*June 6* 19*46* at *8:50* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*Oct.* 19*75* to *June 6* 19*46*  
 and that I last saw him alive on *June 6* 19*46*

Immediate cause of death.....  
 DURATION

*Carcinoma Prostate*  
 Due to.....*Gland & Bladder*

Due to.....*Carcinomatous*

Due to.....*Benign*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE.....*Charles J. Foley, M.D.*  
 Address.....*Harford Co. Md.*

Date signed.....*June 6, 1946*

RECEIVED

JUL 3 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITY OF BALTIMORE

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

## CERTIFICATE OF DEATH

★06025

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or special address where death occurred:

825 So. Market St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)Street No. 825 So. Market St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Alice Chesney

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Benj. Chesney7. Birth date of deceased (mo., day, yr.) Sept. 14, 1852

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years 93 Months 9 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford Co. MD.  
(Town, county, and state)10. Usual occupation House Duties11. Industry or business Retired 40 yrs.12. Name Elijah Thompson13. Birthplace MD.14. Maiden name Martha Forsythe15. Birthplace MD.18. Informant Mrs. Grace L. CurrierAddress 825 So. Market St. City17. Burial Date thereof June 23, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wesleyan ChapelLocation Harford Co. MD.18. Funeral director H. Madison MitchellAddress Harford Co. MD.19. June 22 19 46 A. L. Lewis MD  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 16 19 44 to June 20 19 46and that I last saw him alive on June 20 19 46Immediate cause of death Cerebral Hemorrhage

## DURATION

Due to Cerebral HemorrhageChronic Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. L. Lewis MD M. D. or otherAddress Harford Co. MD. Date signed 6-22-46

RECEIVED

JUN 25 1946

BUREAU V 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

## CERTIFICATE OF DEATH

106026

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford CoCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Jappa  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Baby Boy

## 3. (b) Social Security Number

Chisholm4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorcedNewborn

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1946 at 12<sup>30</sup> A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Hydrocephalus

DURATION

1 mi

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Gerald C Palmer M.D.

M. D. or other

Address Bellaire, Md. Date signed 6/23/46

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) June 23 - 1946

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. 1 min.9. Birthplace Harford Co, Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Clifton Chisholm13. Birthplace Md.14. Maiden name Pauline Bruce15. Birthplace Elkton, Md.16. Informant HospitalAddress Harford Memorial Hospital17. Burial Date thereof June 23 - 46  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory Forest Mt. C.Location Forest Mt. C.18. Funeral director Clarence E. ArthurAddress Forest Mt. C.Date rec'd by registrar June 23 1946 Registrar G. L. Lewis M.D.

RECEIVED  
JUN 25 1946  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06027/80

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Harford Co.

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 205

(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

Charles Edward Christopher Jr

### 3. (b) Social Security Number

4. Sex m

5. Color or race w

6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-1986

8. AGE: Years Months Days If less than one day

60

9. Birthplace Baltimore

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Charles E. Christopher

13. Birthplace Baltimore

14. Maiden name Mary A. Chapman

15. Birthplace Md

16. Informant hus wife's Phelps

Address Baltimore

17. Buried Date thereof 8-10-46

(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Cathlamet

Location Baltimore

18. Funeral director Levinson

Address 5305 Harford Rd.

19. 6/8 19 46 1710 Edgewood, Md

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 46 at 8 15 p.m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 18 19 46 to June 7 19 46

and that I last saw him alive on June 6 19 46

Immediate cause of death carcinosis of the liver

DURATION

1 yr

Due to not known

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ned O. Hodons, M.D.

M. D. or other

Address Edgewood, Md Date signed 6-7-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06028

182

Reg. Dist. No. 189

## 1. PLACE OF DEATH:

County HarfordCity or town Harlington  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Harlington  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION) Mr

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Geo. P. Cook

## 3. (b) Social Security Number

Mr4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife Mr7. Birth date of deceased (mo., day, yr.) Jan. 18, 1855 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 91 Months 5 Days 12 it less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford Co., Md.  
(town, county, and state)10. Usual occupation Farm11. Industry or business Farming12. Name Geo. P. Cook13. Birthplace Penna14. Maiden name Martha Beeson15. Birthplace Penna16. Informant Mr Charles CookAddress 227 A. Monroe St. Brooklyn 16 N.Y.17. Burial (Burial, cremation, or removal? Which?) Burial Date thereof July 3, 1946  
(month) (day) (year)Cemetery or crematory Harlington CemLocation Harford Co., Md.18. Funeral director H. S. BaileyAddress Harlington, Md.19. July 1 46 M. V. Turk

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 46 8 a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 19 46 to June 30 19 46and that I last saw him alive on June 28 19 46Immediate cause of death Coronary Endocarditis DURATION 1 yrDue to Enlarged prostate 3 yr

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. S. Bailey M. D. or otherAddress Harlington Date signed 6/30/46



RECEIVED  
AUG 10 1946  
BUREAU VS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75-2

## CERTIFICATE OF DEATH

06029

8

Reg. Diat. No. 185

1. PLACE OF DEATH: Harford  
County.....  
City or town.....Harford  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....md.....County.....Baltimore  
City or town.....Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 222 Detroit Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME

Allan O. Evelyn

3. (b) Social Security Number

4. Sex.....male.....5. Color or race.....white.....6. (a) Single, married, widowed, or divorced.....married  
6. (b) Name of husband or wife.....Ada C. Evelyn  
6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.).....February 14, 1881  
8. AGE: Years.....65.....Months.....5.....Days.....22.....hrs.....min.  
9. Birthplace.....Barbados, British West Indies  
(Town, county, and state)  
10. Usual occupation.....Full Inspector  
11. Industry or business

MOTHER FATHER  
12. Name.....Edward Evelyn  
13. Birthplace.....British West Indies  
14. Maiden name.....Sarah E. Roach  
15. Birthplace.....British West Indies  
16. Informant.....Mrs. Ada C. Evelyn  
Address.....222 Detroit Ave. Dundalk  
17. Burial.....June 8, 1946  
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)  
Cemetery or crematory.....Oakblawn  
Location.....Eastern Avenue  
18. Funeral director.....Roland L. Fisher  
Address.....2112 Dundalk Ave. Dundalk  
19. 6-7-46  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....June 5.....1946.....at.....4:15.....P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19.....to.....19.....  
and that I last saw h.....alive on.....19.....  
Immediate cause of death.....Fracture liver.....DURATION.....2 days  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)  
Major findings of operations.....Fracture liver.....Date of op. 6/3/46  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide.....Accident.....Date of.....6/3/46  
Where did injury occur?.....Perryville Cecil md.  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....Boat yard  
Means of injury.....Hit.....Injured at work?.....yes  
23. SIGNATURE.....Gerald C. Palmer M.D.  
.....Deputy Medical Examiner  
.....Harford County.....M. D. or other  
Address.....Baltimore, md......Date signed.....6/5/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

06030

Reg. Dist. No. 184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County HarfordCity or town street  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 31

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah Lenora Gallbreath

## 3. (b) Social Security Number

213-01-99034. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife T. C. Gallbreath6. (c) If alive, give age alive years7. Birth date of deceased (mo., day, yr.) August 29, 19148. AGE: Years 31 Months 9 Days 22 hrs. min.9. Birthplace Harford Co., Md.  
(town, county, and state)10. Usual occupation Housework11. Industry or business at home12. Name Charles M. Burkheim13. Birthplace Harford Co., Md.14. Maiden name Catherine Lagan15. Birthplace Harford Co., Md.16. Informant Mr. T. C. GallbreathAddress street, Md.17. Burial Date thereon June 14, 1946  
(Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory Emory CemLocation Harford Co., Md.18. Funeral director H. S. BaileyAddress Darlington, Md.Date June 13, 46 Registrar M. H. Hark

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town street  
(If outside city or town limits, write RURAL and give nearest town)Street No. no  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 46 at 2:30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 19 46 and that I last saw him alive on June 10 19 46Immediate cause of death Pneumonia DURATIONDue to tuberculosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Beyan Sorgi W  
M. D. or otherAddress CARDIFF Date signed June 15, 46

RECEIVED  
JUN 26 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1342)

06031

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County HowardCity or town Farm Grove P.O.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Farm Grove P.O.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3.(a) FULL NAME

William F. Heaton

## 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married8.(b) Name of husband or wife Royal Heaton7. Birth date of deceased (mo., day, yr.) Nov 27 1877 8.(c) If alive, give age 30 years8. AGE: Years 48 Months 4 Days 3 If less than one day ..... hrs. .... min.9. Birthplace Howard Co. Md  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming12. Name Wm. Heaton13. Birthplace Howard Co. Md14. Maiden name Adeline Cherry15. Birthplace Howard Co. Md16. Informant Royal HeatonAddress Farm Grove P.O.17. Burial Date thereof July 3 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FiddlersLocation Howard Co. Md18. Funeral director Wm. HeatonAddress Farm Grove P.O.July 3d 1946 Thomas R. Brown

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1946, at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him in on June 28 1946Immediate cause of death Calculus ofbladder

Due to .....

Due to .....

Other conditions .....

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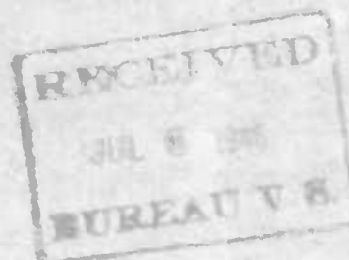
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

06032

## 1. PLACE OF DEATH:

County HarfordCity or town Harre de Chase  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harre de Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. Warren & Columbia Sts.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

U. Oliver Hill

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Negro

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 11, 1894

6. (c) If alive, give age ..... years

## 8. AGE:

62 Years 4 Months 1 Days If less than one day ..... hrs. .... min.

## 9. Birthplace

Harre de Chase  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

## 13. Birthplace

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. June 15, 1946

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1946, at 9:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8 1946, to June 13 1946, and that I last saw him alive on June 13 1946.

Immediate cause of death

Laryngeal andPulmonary tuberculosis

Due to

Due to

Other conditions

Cachexia

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

Address

Injured at work?

M.D. or other

Date signed June 15, 1946



RECEIVED  
JUN 19 1946  
BUREAU V.B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

06033

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County HarfordCity or town BEL Air  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

138 Main St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town BEL Air  
(If outside city or town limits, write RURAL and give nearest town)Street No. 138 Main St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Ada Roberta Young Hollingsworth

## 3. (b) Social Security Number

4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Charles AnnHollingsworth 6. (c) If alive, give age \_\_\_\_\_ years7. Birth date of deceased (mo., day, yr.) November 5 18628. AGE: Years 83 Months 7 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford County  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name William Young13. Birthplace Baltimore14. Maiden name Mary Elizabeth Cochran15. Birthplace Harford County16. Informant Roberta HollingsworthAddress Charlottesville Va.17. Burial Date thereof June 16 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Little Falls FriendsLocation Faaleston, Md18. Funeral director Howard K. McCombsAddress Abingdon Md19. 6/15 46 Priscilla Lowry  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 46, at 11:58 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 21, to June 13 19 46and that I last saw her alive on June 13 19 46Immediate cause of death Acute Myocardial failure

DURATION

12 hr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE M. D. or otherAddress BEL Air Md Date signed 6/14/46

RECEIVED

RECEIVED

RECEIVED

JUN 18 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

06034

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County HarfordCity or town Farm Cove P.O.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HarfordCity or town Farm Cove P.O.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James E. Esaminger

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ella Esaminger

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Dec 4, 1880

8. AGE:

Years

65

Months

6

Days

11

If less than one day

hrs. min.

9. Birthplace

Hamilton Ohio  
(Town, county, and state)

10. Usual occupation

Retired Sports Writer

11. Industry or business

Sports Writer

MOTHER

FATHER

12. Name

George W. Esaminger

13. Birthplace

Ohio

14. Maiden name

Ella Robinson

15. Birthplace

Ohio

16. Informant

Ella Esaminger

Address

Farm Cove P.O.

17. (Burial, cremation, or removal. Which?)

CremationDate thereof June 19, 1946  
(month) (day) (year)

Cemetery or crematorium

West Farm Hill

Location

Philadelphia Pa

18. Funeral director

W. Howard Webb

Address

Farm Cove Pa19. June 19, 1946  
(Date rec'd by registrar)Thomas R. Brown  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1946 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15, 1846 to June 17, 1946and that I last saw him alive on June 17, 1946Immediate cause of death Chronic  
nephritis, chronic myocarditis  
& cirrhosis  
Due to Hemiplegia five  
years ago.

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Norman H. Gemmill  
M. D. or otherAddress Stewartstown Pa. Date signed 6/17/46

RECEIVED  
JUN 21 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (M)

## CERTIFICATE OF DEATH

06035

Reg. Dist. No. 180

## 1. PLACE OF DEATH:

County... Harford  
 City or town... Edgewood, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Station Hospital, Edgewood Arsenal, Md.How long in hospital or institution? Five hours.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Kansas County...City or town... Kansas City  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 802 Shawnee Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war... World War II ★

## 3. (a) FULL NAME

JAMES I. JOHNSON

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

6. (b) Name of husband or wife. ----

7. Birth date of deceased (mo., day, yr.) 29 April 1917 6. (c) If alive, give age ---- years8. AGE: Years Months Days If less than one day  
29 1 6 .....hrs. ....min.9. Birthplace... Belle, Missouri  
 (Town, county, and state)10. Usual occupation... U. S. Army11. Industry or business #12. Name... Unknown

13. Birthplace

14. Maiden name... Unknown

15. Birthplace

16. Informant U. S. Records

Address

17. Transportation Date thereof June 5, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cressman Funeral HomeLocation Belle, Mo.18. Funeral director Howard K. McNameeAddress Abingdon Maryland19. June 5 19 46 Maud M. Mouldale  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 4 June 19 46 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 June 19 46 to 4 June 19 46and that I last saw him in alive on 4 June 19 46Immediate cause of death... Toxemia, pulmonary edema, due to burns, third degree, ninety percent of body.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

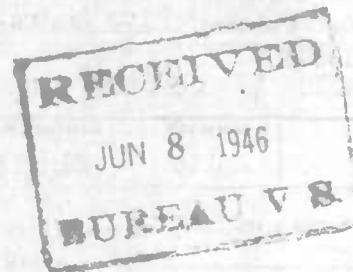
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... accident Date of 4 June 46Where did injury occur? Edgewood Arsenal, Edgewood, Md.  
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Edgewood ArsenalMeans of injury Burns Injured at work? Yes23. SIGNATURE James I. Johnson James I. Johnson  
 M. D. or otherAddress... Station Hospital Date signed 4 June 46

✓  
MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

#1





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

06036

Reg. Dist. No. 182

1. PLACE OF DEATH: Hartford  
 County.....  
 City or town..... Bel Air Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 42 years  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... MD County..... Hartford  
 City or town..... Bel Air, MD (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3.(a) FULL NAME G Frank Jones

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced M  
 6.(b) Name of husband or wife..... Elizabeth R Cole  
 8.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) July 23 - 1862  
 8. AGE: Years 83 Months Days If less than one day  
 ..... hrs. .... min.

9. Birthplace..... Forest Hill MD  
 (Town, county, and state)  
 10. Usual occupation..... Retired Farmer  
 11. Industry or business

12. Name..... San't W Jones  
 13. Birthplace..... MD  
 14. Maiden name..... Amanda Ford  
 15. Birthplace..... Baltimore, MD

16. Informant..... Mrs Elizabeth R Jones  
 Address..... Bel Air, MD

17. Burial Date thereof..... June 15/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Mt Zion  
 Location..... Fountain Green, MD

18. Funeral director..... Dean & Fisher  
 Address..... Bel Air Md

19. 6/15 46 Priscilla Toward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... JUNE 13 1946 at 11A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Aug 1942 to June 1946  
 and that I last saw him alive on June 12 1946

Immediate cause of death..... Cerebral Hemorrhage DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Bel Air Md Date signed..... 6/14/46

RECEIVED

JUN 18 1946

BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS COUPON IS LIMITED TO

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06037

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford  
 City or town Leam's Cove  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hr.  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
 How long in hospital or institution? 2 hr.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Jappa  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William David Jones

## 3. (b) Social Security Number \_\_\_\_\_

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Newborn

## 6. (b) Name of husband or wife \_\_\_\_\_

## 7. Birth date of deceased (mo., day, yr.)

6/20/46

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

2 hrs. \_\_\_\_\_ min.

## 9. Birthplace

Name de Cove, Harford, Md.  
(Town, county, and state)

## 10. Usual occupation

Newborn

## 11. Industry or business \_\_\_\_\_

## FATHER

## 12. Name

Walter Rump Jones

## 13. Birthplace

North Gardens

## MOTHER

## 14. Maiden name

Laura Estlin Howell

## 15. Birthplace

North Gardens

## 16. Informant

Walter R. Jones

## Address

Edgewood R. W. Rd

## 17. (Burial, cremation, or removal. Which?)

Burial

## Date thereof

June 21 1946  
(month) (day) (year)

## Cemetery or crematory

Oak Grove

## Location

Fountain Green, rapid Rd

## 18. Funeral director

Howard R. McCombs & Sons

## Address

Abingdon Maryland

## 19. (Date rec'd by registrar)

June 20 1946G. L. Lewis M.D.  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

6/20

19

46 at 9:20 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/20 1946 to 6/20 1946  
and that I last saw him alive on 6/20 1946

## Immediate cause of death

Reached Esophageal fistula

## DURATION

2 hr.

## Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

## Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

## Autopsy results \_\_\_\_\_

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date et \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Rudley Phillips MD  
Harford Mem. Hosp. Date signed 6/20/46

RECEIVED  
JUN 22 1946  
BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

06038

Reg. Dist. No. 189

1. PLACE OF DEATH: Harford  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....69  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
Md  
State..... County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION) Mo  
2.(a) If veteran, name war.....

3. (a) FULL NAME James C. Kelly

3. (b) Social Security Number Mo

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1877 8.(c) If alive, give age..... years

8. AGE: Years 69 Months 4 Days 7 If less than one day..... hrs. .... min.

9. Birthplace Harford Co., Md  
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business House wiring

12. Name Robert G. Kelly

13. Birthplace Cecil Co. Md.

14. Maiden name Annie Crowl

15. Birthplace Cheston Co. Penna.

16. Informant Mrs. Reba Morris

Address Street, Md. R. D.

17. Burial Burial Date thereof June 20, 1946  
(Burial, cremation, or removal, where?) (month) (day) (year)

Cemetery or crematory Thomas Run Cem

Location Harford Co., Md.

18. Funeral director H. D. Bailey

Address Darlington, Md.

19. July 8, 46 M. G. Kirk  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1946, at 10:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1946, to June 17 1946

and that I last saw him alive on June 10 1946

Immediate cause of death Crown Thrombosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE W. E. Gallion M. D. or other

Address Darlington Date signed 6-19-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 11 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

06039

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County.....Harford  
 City or town.....Cardiff  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....6 yrs.  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland.....County.....Harford  
 City or town.....Cardiff  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Zua L. Lane

## 3.(b) Social Security Number

4. Sex.....Female  
 5. Color or race.....White  
 6.(a) Single, married, widowed, or divorced.....Widowed  
 6.(b) Name of husband or wife.....William H. Lane  
 6.(c) If alive, give age.....years  
 7. Birth date of deceased (mo., day, yr.).....April 19, 1871  
 8. AGE: Years.....75 Months.....1 Days.....20 If less than one day.....hrs. ....min.

9. Birthplace.....York Co. Pa.  
 (Town, county, and state)  
 10. Usual occupation.....Housewife  
 11. Industry or business.....

FATHER 12. Name.....John T. Boyd  
 13. Birthplace.....Chester Co. Pa.  
 MOTHER 14. Maiden name.....Rachel Dunlap  
 15. Birthplace.....York Co. Pa.

16. Informant.....Margaret Lane Boyle  
 Address.....Cardiff, Md.

17. Burial.....June 11, 1946  
 (Burial, cremation, or removal. Which?) Date thereof.....(month) (day) (year)  
 Cemetery or crematory.....Mt. Nebo cemetery  
 Location.....Delta, Pa.

16. Funeral director.....Hubert P. Harkins  
 Address.....Delta, Pa.

June 10, 1946 M.D. Kirdp  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....June 9.....1946.....at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 June 2.....1946.....to June 8.....1946.....  
 and that I last saw h.e. alive on June 8.....1946.....

Immediate cause of death.....  
 Cerebral Hemorrhage  
 Due to.....Arteriosclerosis  
 Hypertension  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 9 months of death)

## DURATION

6 days

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide.....Date of.....  
 Where did injury occur?.....(City or town).....(County).....(State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury.....Injured at work?

23. SIGNATURE.....Edward H. Hiron  
 M. D. or other  
 Address.....Fawn Shore, Pa.  
 Date signed.....6/10/46

STANDARD TIME CHARTING CO. NEW YORK

STANDARD TIME CHARTING CO. NEW YORK

RECEIVED

JUN 26 1946

BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

## CERTIFICATE OF DEATH

06040

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County Harford  
 City or town Harre de Grace, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.

How long in hospital or institution?

4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Harre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Market St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Mackie

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

March 16, 1891

8. AGE:

Years

Months

Days

If less than one day

55223

hrs.

min.

8. Birthplace

Harre de Grace, Md.  
(Town, county, and state)

10. Usual occupation

House Worker

11. Industry or business

FATHER

12. Name

Joseph Mackie

13. Birthplace

Ireland

MOTHER

14. Maiden name

Mary Crane

15. Birthplace

Maryland

18. Informant

Hosp. Records

Address

Harre de Grace

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6/12/46  
(month) (day) (year)

Cemetery or crematory

Mt. Airy

Location

Harre de Grace

18. Funeral director

Mr. Pennington

Address

Washington St. City

19. June 11

(Date rec'd by registrar)

19. 46

G. L. Lewis M. D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1946, at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5 1946, to June 8 1946  
and that I last saw him alive on June 8 1946

Immediate cause of death

acute myocarditis

DURATION

2 days

Due to

adenocarcinoma

Due to

lung

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

E. J. Simon

M. D. or other

Address

Harre de Grace

Date signed

6-9-46

RECEIVED  
JUN 13 1984  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 hrs 30 min

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 13 hrs 30 min

## 3. (a) FULL NAME

Margaret KathleenBaby GirlMcCall

3. (b) Social Security Number

4. Sex F5. Color or race W.6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 6-22-46

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day

13 hrs 30 min.9. Birthplace Harford Memorial Hospital, Harre de Grace, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Nelson Heider McCall13. Birthplace Charlestown, Md14. Maiden name Margaret D. Wray15. Birthplace Wilmington Del16. Informant Nelson McCallAddress Charlestown, Md17. Burial Date thereof 6-23-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory CharlestownLocation Charlestown, Md18. Funeral director Joseph R. GrantAddress North East, Md19. June 22 19 46 G. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. CecilCity or town Charlestown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6-23-46 19\_\_\_\_, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-22-46 19\_\_\_\_ to 6-22-46 19\_\_\_\_and that I last saw him alive on 6-22-46 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

DURATION 13 hrsPrematurity

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. L. Lewis M.D. M. D. or otherAddress Harre de Grace, Md Date signed 6-22-46

RECEIVED

JUN 26 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06042-185-  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County HarfordCity or town Harvred Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

314 Bourton St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Harvred Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 314 Bourton St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Edward McCommons

## 3. (b) Social Security Number

218-03-8961

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elsie L. McCommons

7. Birth date of

deceased (mo., day, yr.)

Oct. 4, 18858. (c) If alive, give age 44 years

8. AGE:

Years 60Months 8Days 10

If less than one day

hrs. min.

9. Birthplace

Harvred Grace Md.  
(Town, county, and state)

10. Usual occupation

Watchman

11. Industry or business

Retired

12. Name

Henry McCommons

13. Birthplace

Md.

14. Maiden name

Aurilla McCommons

15. Birthplace

Md.

16. Informant

Mrs. Elsie L. McCommonsAddress 314 Bourton St. City -17. Burial

(Burial, cremation, or removal-Which?)

Date thereof

June 16, 1946  
(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Harvred Grace Md.

18. Funeral director

R. Madison Mitchell

Address

Harvred Grace Md.19. June 15 - 1946

(Date rec'd by registrar)

G. L. Lewis M. D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1940 to June 14, 1946and that I last saw him alive on June 14, 1946

Immediate cause of death

Pulmonary edema

Due to

chronic myocarditis

Due to

chronic bronchitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Unbehut M.D.

M. D. or other

Address Harvred Grace Date signed June 15

RECEIVED  
JUN 19 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE DEPARTMENT OF HEALTH

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

06043

## CERTIFICATE OF DEATH

Reg. Diat. No.

185

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1946

G. L. Lewis M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

JUNE 16

1946

at 4:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him

alive on

19

Immediate cause of death

SHOCK, HEMORRHAGE, AND PERITONITIS

Due to

GUNSHOT WOUND OF ABDOMEN

Due to

Other conditions

DURATION

(Include pregnancy within 8 months of death)

Major findings of operations

MULTIPLE PERFORATIONS OF SMALL AND LARGE BOWEL

Date of op. JUNE 15, 1946

Autopsy results

NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

HOMICIDE

Date of JUNE 15, 1946

Where did injury occur

HARRIS DE GRACE HARBOR

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

HOME

Means of injury

22 CAL RIFLE

Injured at work?

NO

23. SIGNATURE

J. W. LAMSON M.D.

M. D. or other

Address

ABERDEEN, M.D.

Date signed JUNE 17, 1946

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED  
JUN 22 1946  
BUREAU V.S.

RECEIVED

RECEIVED

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-a

## CERTIFICATE OF DEATH

★ 06044

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County HarfordCity or town Aberdeen Proving Ground, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long to hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen Proving Ground  
(If outside city or town limits, write RURAL and give nearest town)Street No. Quarters 107  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Michael Nisevich

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 26 March 1946

8. AGE: Years Months Days If less than one day

224hrs.min.9. Birthplace Hayre de Grace, Harford County, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Stanley J. Nisevich13. Birthplace Podovia, JugoslaviaMOTHER 14. Maiden name Mary Spear15. Birthplace Hammond, Indiana16. Informant Stanley J. NisevichAddress Aberdeen Proving Ground Md17. Transportation Transportation

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Emmending Funeral ChapelLocation 5322, 11thman Dr, Hammond, Ind18. Funeral director Howard K. McConnaughyAddress Abingdon Maryland19. June 29 1946 Nellie H. Riley

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 June 19 46 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h. alive on 19

Immediate cause of death Subdural hemorrhageAtelectasis both lower lungs

DURATION

Due to The sub-dural hemorrhage was spontaneous — not due to accident or injuryDue to Duration: two days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter Pick Capt. M.C.Address Stetson Hosp. A.P.G.

M. D. or other

Date signed 25 June 1946



CERTIFICATE OF DEATH

RECEIVED  
JUL 3 1946  
BUREAU V R

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 06045 181

### 1. PLACE OF DEATH:

County Harford  
City or town RD #1 Harford Harford md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? two years  
Hospital, institution, or street address where death occurred:  
RD #1 Harford Harford md  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Harford  
City or town RD #1 Harford Harford md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION) none  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Cornelius Warner Pickett

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Magnolia Pickett  
deceased 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 31 - 1869

8. AGE: Years 76 ~~1869~~ Months 9 Days 9 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Carroll County  
(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business \_\_\_\_\_

12. Name Warner Pickett

13. Birthplace Carroll County

14. Maiden name Kenish Hull

15. Birthplace Carroll County

16. Informant Mr Pickett

Address 1252 20th St. Wash. D.C.

17. Burial, cremation, or removal. Which? Burial Date thereof June 12-1946  
(month) (day) (year)

Cemetery or crematory Cemetery

Location Savage Md

18. Funeral director Floyd Kaiser

Address Laurel md.

19. June 10 1946 Bertha B. Knight Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1946 at 11:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to June 9 1946.

and that I last saw him alive on June 9 1946

Immediate cause of death \_\_\_\_\_

Arterio Sclerosis

Due to Central Hemorrhage

Due to \_\_\_\_\_

Other conditions Cerebral

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles J. Foley M.D. M.D. or other \_\_\_\_\_

Address Harford Harford md Date signed 6/10/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

\* 06046

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Harford  
 City or town Cardiff  
 (If outside city or town limits write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford  
 City or town Cardiff  
 (If outside city or town limits write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

David Pyle

## 3. (b) Social Security Number

4. Sex M 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Bertha A. Pyle7. Birth date of deceased (mo., day, yr.) Aug 13 1879 6. (c) If alive, give age 61 years

8. AGE: Years 66 Months 10 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace York Co., Pa. (Town, county, and state)10. Usual occupation Salesman

11. Industry or business

12. Name Nathan L. Pyle13. Birthplace Harford Co., Md.14. Maiden name Caroline Pieper15. Birthplace Harford Co., Md.16. Informant Bertha Ayres PyleAddress Cardiff, Md.17. Burial Date thereof June 22 1946 (month) (day) (year)Cemetery or crematory Slate Ridge CemLocation Delta, Pa.18. Funeral director Hubert P. SearkinsAddress Delta, Pa.19. July 8 46 19 46 Registrar M. W. Kirtz

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1946 at 4:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1946 to June 20 1946and that I last saw him alive on June 20 1946Immediate cause of death Coronary thrombosisDue to Coronary sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

(Include pregnancy within 3 months of death)

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jenish A. Hunt M.D. M. D. or otherAddress Cardiff, Md. Date signed 6/20/46

CERTIFICATE OF DEATH

JUL 10 1946

RECEIVED  
JUL 10 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06047

★ Reg. Dist. No. 195

## 1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? about 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 802 Erie  
(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

Mary Simone

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife Tringio Simone (dec.)7. Birth date of deceased (mo., day, yr.) April 23 - 1876  
6. (c) If alive, give age..... years8. AGE: Years 70 Months 2 Days 24 If less than one day  
.....hrs. ....min.9. Birthplace Italy  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Valentino Delano13. Birthplace Italy14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Lilly ThioAddress 802 Erie St. Harre de Grace17. Burial Date thereof 6/25/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. ErinLocation Harre de Grace18. Funeral director Pennington & SonAddress Harre de Grace19. June 28 19 46 G. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 - 1946, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 10 19 42, to June 25 19 46and that I last saw him alive on June 25 19 46

Immediate cause of death

Cerebral HemorrhageHypertension

Due to

Cerebral Hemorrhage

Due to

Toxemia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Kelly M.D.Address Harre de Grace Date signed 6/27/46



RECEIVED  
JUL 2 1945  
BUREAU V.E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06048

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 186

## 1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

220 So. Stokes St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 220 So. Stokes St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Prissilla Singleton

## 3. (b) Social Security Number

?

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Stephen J. Singleton

## 7. Birth date of

deceased (mo., day, yr.)

Oct. 2, 1858

6. (c) If alive, give age..... years

## 8. AGE:

Years 87Months 8Days 7

If less than one day

.....hrs. ....min.

## 9. Birthplace

Harford Co. Md.

(Town, county, and state)

## 10. Usual occupation

House Duties

## 11. Industry or business

Retired

FATHER

## 12. Name

Thomas Sampson

## 13. Birthplace

Md.

MOTHER

## 14. Maiden name

Emily Crew

## 15. Birthplace

Md.

## 16. Informant

Mrs. Laura V. Wright

## Address

220 So. Stokes St

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 11, 1946

(month) (day) (year)

## Cemetery or crematory

Smith's Chapel

## Location

Harford Co. Md.

## 18. Funeral director

R. Madison Mitchell

## Address

Harre de Grace, Md.

## 19. June 10 1946

(Date rec'd by registrar)

G. L. Lewis, Jr.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 9, 1946, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4, 1946 to June 9, 1946and that I last saw her alive on June 4, June 8, 1946

Immediate cause of death

cardiac failure

DURATION

1 day

Due to

Chronic myocarditis

20 years

Due to

hypertension of age

Other conditions

.....

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

Paul Unbeck M.D.

M. D. or other

Address

Harre de GraceDate signed June 10, 1946

RECEIVED  
JUN 12 1946  
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06049

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Rosalie Jane Singleton4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Thomas Singleton7. Birth date of deceased (mo., day, yr.) Aug 2, 18926. (c) If alive, give age 46 years8. AGE: Years 53 Months 8 Days 1 If less than one day hrs. min.9. Birthplace Harford Co. Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Vinton J. Cullen13. Birthplace Maryland14. Maiden name Margaret Thompson15. Birthplace Maryland16. Informant Thomas SingletonAddress Abingdon Maryland17. Burial Burial Date thereof June 5, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GroceLocation Abingdon Maryland18. Funeral director Howard K. McCombsAddress Abingdon Maryland19. June 10, 1946 Nellie Riley  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Abingdon  
(If outside city or town limits, write RURAL and give nearest town)Street No. Abingdon  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1946 at 9:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 46 to June 3, 1946and that I last saw him alive on June 2, 1946Immediate cause of death Uterus

DURATION

Due to Carcinoma of Uterus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Uterus involvingmetastases Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE GB Jastrow MDAddress Abingdon Date signed June 5, 1946

WASHINGTON STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RHC

JUL 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17a

## CERTIFICATE OF DEATH

06050

Reg. Dist. No.

## 1. PLACE OF DEATH:

County HARFORDCity or town ABERDEEN  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? NOT KNOWN

Hospital, institution, or street address where death occurred:

PHILADELPHIA ROADHow long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Unknown County UnknownCity or town Unknown  
(If outside city or town limits, write RURAL and give nearest town)Street No. —  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

FRANCIS ANDY SUMNER

## 3. (b) Social Security Number

579-12-6829

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

Unknown6.(b) Name of husband or wife —6.(c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years Months Days If less than one day

About 55— hrs. — min.9. Birthplace Unknown  
(Town, county, and state)10. Usual occupation Unknown11. Industry or business Unknown12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant John E. TanningAddress 106 Rogers St. Aberdeen Md17. Burial Date thereof June 17-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HomeLocation Aberdeen Md18. Funeral director Benny Tanning, GoodAddress Aberdeen Md19. June 17 1946 Registrar Nellie Z. Riley  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 13 19 46 at 11:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

— 19 —, to — 19 —and that I last saw him — alive on — 19 —Immediate cause of death CEREBRAL HEMORRHAGETRAUMATIC

DURATION

Due to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of JUNE 13, 1946Where did injury occur ABERDEEN HARFORD MD  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) PUBLIC ROADMeans of injury STRUCK BY TRUCK Injured at work? No23. SIGNATURE J. J. Tanning M.D.Address Aberdeen, Md. Date signed June 14, 1946

RECEIVED

JUL 3 1946

BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

## 1. PLACE OF DEATH:

County Harford  
City or town Edgewood, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Station Hospital, Edgewood Arsenal, Md.How long in hospital or institution? Ten hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Mexico CountyCity or town Isleta  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war World War II ★ ✓

## 3. (a) FULL NAME

Jose M. Velardez

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \*\*

7. Birth date of deceased (mo., day, yr.) 16 April 1920 6. (c) If alive, give age years

8. AGE: Years 26 Months 1 Days 18 If less than one day  
hrs. min.

9. Birthplace Isleta, New Mexico  
(Town, county, and state)

10. Usual occupation U S Army

11. Industry or business

12. Name Jose J. Velardez13. Birthplace Unknown14. Maiden name Unknown

15. Birthplace

16. Informant U S Records

Address

17. Transportation Date thereof June 6, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Jose M. VelardezLocation Isleta, New Mexico18. Funeral director Howard L. McCombsAddress Abingdon Maryland

19. June 6, 19 46 Mae M. Mouldale  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 June 19 46 at 8:26 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
4 June 19 46, to 4 June 19 46

and that I last saw him alive on 4 June 19 46

Immediate cause of death Toxemia, pulmonary edema

DURATION

Due to burns, third degree, ninety percent of body.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4 June 46

Where did injury occur? Edgewood Arsenal, Edgewood, Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Edgewood Arsenal

Means of injury Burns Injured at work? Yes

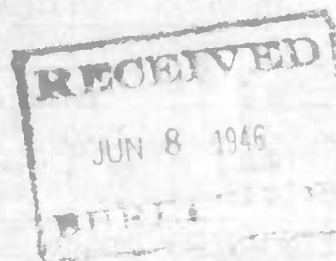
23. SIGNATURE Frederick W. McKim Cap. M.C.  
M. D. or other

Address Station Hospital Date signed 4 June 46



Bessman

Belle or Bill City



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06052

Reg. Dist. No. 183

### 1. PLACE OF DEATH:

County Harford

City or town Pylesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford

City or town Pylesville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

James Edwin Webster

### 3. (b) Social Security Number

None

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb 6 1942

8. AGE: Years 4 Months 4 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pylesville Md  
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name John E. Webster Jr

13. Birthplace Pylesville Md

14. Maiden name Channon Bortol

15. Birthplace Pylesville Md

16. Informant John E. Webster

Address Pylesville Md

17. Burial Date thereof June 2, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Marys

Location Pylesville Md

18. Funeral director W. Howard Platt

Address 5 Ann Lane Pa

19. June 21 1946 Thomas R. Brown  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1946 at 5:00 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1942 to June 18 1946 and that I last saw him alive on June 1946

Immediate cause of death Hydrocephalus

DURATION

Due to Brain Abscess

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jonah G. [Signature] M. D. or other

Address Croft Md Date signed 6/20/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 26 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HITHE CORPORATE LIMITED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06053

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford CoCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 633 Linden Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

William Henry Witte

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Irene Witte7. Birth date of deceased (mo., day, yr.) April 15 19236.(c) If alive, give age 20 years8. AGE: Years 23 Months 1 Days 27 If less than one day  
.....hrs. ....min.9. Birthplace Baltimore  
(Town, county, and state)10. Usual occupation Riveter11. Industry or business Glen L. Martin12. Name William H. Witte13. Birthplace Balto, Md14. Maiden name Mary Stewart15. Birthplace Balto, Md16. Informant Mary WitteAddress 633 Linden Lane17. Burial Date thereof 6/15/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BaltimoreLocation Baltimore Md18. Funeral director William Cook Inc.Address St. Paul & Preston St.19. June 12 1946 G. L. Lewis, Jr.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1946 at 6:00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to June 12 1946and that I last saw him alive on June 12 1946Immediate cause of death Hodgkin'sDue to DiseaseDue to CancerOther conditions Encephalitis

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. FilyAddress Harre de Grace MdDate signed 6/12/46

RECEIVED

JUN 15 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06054

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County HarfordCity or town Garrettsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Garrettsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sophia matelda Zinkhan

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

B. (b) Name of husband or wife

William C Zinkhan

7. Birth date of deceased (mo., day, yr.)

Feb 7 18616. (c) If alive, give age 85 years

8. AGE:

Years

Months

Days

If less than one day

8543

hrs.

min.

9. Birthplace

Garrettsville  
(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

FATHER  
MOTHER

12. Name

Christian Schisler

13. Birthplace

Germany

14. Maiden name

Martha Harwick

15. Birthplace

Germany

16. Informant

Joseph Zinkhan

Address

Forest Hill Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

June 12 1946

(month) (day) (year)

Cemetery or crematory

Wm. Watters Memorial

Location

Croftown Md

18. Funeral director

Martin H. Kurtz

Address

Garrettsville, Md.

19. June 12

(Date rec'd by registrar)

1946

Thomas R. Brown

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 10, 1946 at 1258

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 25, 1945 to June 9, 1946and that I last saw her alive on June 9, 1946

Immediate cause of death

bronchial pneumonia

DURATION

5 days

Due to

Cardiac decompensation

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles G. Jeff Md.

M, D, or other

Address

Street, Md.Date signed 6-11-46

RECEIVED

JUN 20 1946

BUREAU V S.